



Division of Licensing and Protection

HC 2 South, 280 State Drive

Waterbury, VT 05671-2060

<http://www.dail.vermont.gov>

Survey and Certification Voice/TTY (802) 241-0480

Survey and Certification Fax (802) 241-0343

Survey and Certification Reporting Line: (888) 700-5330

To Report Adult Abuse: (800) 564-1612

January 30, 2017

Ms. Devida Deluca, Manager
Living Well Residence
1200 North Avenue
Burlington, VT 05408-1004

Dear Ms. Deluca:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on January 3, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

A handwritten signature in black ink that reads "Pamela M. Cota, RN".

Pamela M. Cota, RN
Licensing Chief



Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0543	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED C 01/03/2017
NAME OF PROVIDER OR SUPPLIER LIVING WELL RESIDENCE		STREET ADDRESS, CITY, STATE, ZIP CODE 1200 NORTH AVENUE BURLINGTON, VT 05408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: The Division of Licensing and Protection conducted an unannounced onsite complaint investigation on 1/3/17. A regulatory violation was cited as a result.	R100	Action: All care staff have been inserviced regarding appropriate documentation. All care staff will review the Care Plan for each new admission.	1/5/17
R126	V. RESIDENT CARE AND HOME SERVICES SS=8 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs.	R126	Measures: The House Manager is reviewing all chart notes daily to ensure that all necessary steps have been documented.	1/4/17
	This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to provide necessary psychosocial, nursing or medical care needs for 1 of 2 applicable residents (Resident #2). Findings include: Per record review, the facility failed to notify Resident #2's family or physician as stated in the care plan. Resident #2 was admitted to the facility on 12/19/16. Per staff notes, Resident #2 demonstrated violent and aggressive behaviors towards staff on 5 occasions between 12/25/16 - 1/2/17. These behaviors consisted of swinging at and/or hitting staff. The Resident's care plan for being at risk for violence due to confusion contains a plan of action to notify family and PCP (Primary Care Physician) of any agitation/aggression. There is no indication in the record that this was done. The House Manager		Monitor: The House Manager has set up an electronic tracking system that will alert when a chart note has been added.	1/10/17

Division of Licensing and Protection

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X8) DATE

STATE FORM

STATE FARM
Makela 4 8/21

0002 YFVX11

R.W 1-25-2017

If continuation sheet 1 of 2

Jesus Favallle

House Manager 1/28/17

R12b PDC accepted 11/26/19 Rtkewidgen/psu

01/25/2017 16:30 8024971597

Jan 25 17 11:06a Jeana Lavallee

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PRINTED: 01/12/2017
FORM APPROVED

Division of Licensing and Protection

<p>Division of Licensing and Protection</p> <p>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</p>			
<p>(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:</p> <p>0543</p>		<p>(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____</p> <p>B. WING: _____</p>	<p>(X3) DATE SURVEY COMPLETED</p> <p>C</p> <p>01/03/2017</p>
<p>NAME OF PROVIDER OR SUPPLIER</p> <p>LIVING WELL RESIDENCE</p>		<p>STREET ADDRESS, CITY, STATE, ZIP CODE</p> <p>1200 NORTH AVENUE BURLINGTON, VT 05408</p>	
<p>(X4) ID PREFIX TAG</p>	<p>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</p> <p>R126: Continued From page 1 confirmed this on 1/3/17 at 1:00 PM.</p>	<p>ID PREFIX TAG</p> <p>R126</p>	<p>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</p>
			<p>(X5) COMPLETE DATE</p>